STATE OF NEW MEXICO HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION
E7576 PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT IS FOR GROUPS, ORGANIZATIONS, OR INDIVIDUAL APPLICANTS TO WHOM PAYMENTS WILL BE MADE. IF THE APPLICANT IS AN INDIVIDUAL APPLYING FOR A PROVIDER NUMBER ONLY FOR IDENTIFYING SERVICES BILLED THROUGH A GROUP PRACTICE OR OTHER ORGANIZATION AND PAYMENTS WILL BE MADE TO THAT GROUP OR ORGANIZATION, THIS FORM SHOULD NOT BE USED. USE FORM MAD 312 INSTEAD.

RETURN completed application to:
New Mexico Medicaid Project
c/o ACS
1720 - A Randolph Rd.
Albuquerque, NM 87106

TO BE COMPLETED BY ALL APPLICANTS:

(1) Name of Applicant: Children's Medical Services
(2) Professional Title (M.D., D.D.S., etc.): PHD/OOH
(3) Physical Location - No. & Street (P.O. Box not accepted. Address at which services are rendered is required) - City - State - Zip Code - County:
(4) Mailing Address or Billing Address (if different from above - official correspondence will be sent to this address) Street or P.O. Box: 2040 South Pacheco City: Santa Fe State: NM Zip Code: 87505
(5) Work Telephone (Area Code): 505-476-9868
(6) State License Number (Attach copy of license):
(7) License Issued By:
(8) License Expiration Date:
(9) Provider Type (See list): 462
(10) Provider Specialty (See list): 061
(11) Social Security Number:
(12) Birth Date For Individuals:

IF PAYMENTS ARE MADE DIRECTLY TO THE APPLICANT, THE FOLLOWING MUST BE COMPLETED.

(13) ☐ an individual ☐ non-corporate business entity ☐ partnership or professional association ☐ sole proprietorship ☐ corporation ☒ governmental entity or public school

(14) Federal Tax Number (Attach Federal Tax letter received from the IRS): 85-6000565
(15) Federal Tax Name (Attach W-9 form):
(16) ☐ Check here if SSN is used in lieu of Tax Number
(17) Doing Business As (Name): Children's Medical Services
(18) NM Tax & Revenue ID Number (If services are provided in NM): 02-17351 0007
(19) ☐ Check here if not-for-profit and attach copy of 501(c)3

COMPLETE IF APPLICABLE:

(20) Medicaid Number (If previously assigned): E7576
(21) HMO Affiliation? ☐ Yes ☒ No. Name of plans in which you participate:
(22) CLIA Number (for providing laboratory services) (Attach copy of certificate):
(23) National Provider ID. (NPI) or UPIN Number (If assigned):
(24) DEA Number (for drug prescriber) (Attach copy of certificate):
(25) NABP # (For Pharmacies):

(26) Are you board certified? ☐ Yes ☒ No If yes, attach a copy of certificate.
If not board certified, attach specialty certification from residency program or letter from the chairperson of your residency program stating that you received training in your specialty area.

(27) CERTIFIED UNDER TITLE XVIII MEDICARE? ☐ Yes ☒ No If yes, attach copy of letter.
JCAHO CERTIFIED? ☐ Yes ☒ No If yes, attach copy of certification letter.

(28) Fiscal Year End Date: 6/30/03

(29) Medicare Provider Number(s) (Attach Medicare letter(s)) — Medicare Carrier or Intermediary:

(30) Identify individuals who will be providing services for which payments will be made directly to your group or organization.

Individual's Name	Title	License Number	Provider Type	Provider Specialty	New Mexico Medicaid Number (If previously assigned)	For Medicaid Project Office Use Only
See Attached						

Please attach a separate page if additional space is needed.

IF THE APPLICANT IS AN INDIVIDUAL, IDENTIFY ANY OTHER ORGANIZATION(S) THAT YOU WILL BILL UNDER:

Organization or Group Name:	Organization or Group Medicaid Number	Organization or Group Medicare Number
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(31) Please attach a separate page if additional space is needed.

(32) Have you ever had a license revoked, suspended or denied in this or any other state? ☐ Yes ☒ No
Have you ever been convicted of any criminal offense? ☐ Yes ☒ No
Have you or any of the owners or principles ever been excluded or suspended from participation in the Title XVIII (Medicare), Title XIX (Medicaid) of any other state's health care programs? ☐ Yes ☒ No
If yes to either or both of these questions, attach a brief statement of situation; date; state, city, county and professional association or court which handled the matter; any precinct case identification; and the adjudication or other result.

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RSHIP INFORMATION - The following information must be provided and updated, as applicable, if payments are remitted to a provider group, partnership, or association:

Name and address of each person with an ownership or controlling interest in the entity or any subcontractors in which entity has or had direct or indirect ownership totaling five percent (5%) or more and whether any of these person(s) named lated to another as spouse, child, or sibling.

me N/A		Social Security Number
dress	Telephone Number	Relationship
ame		Social Security Number
ddress	Telephone Number	Relationship
ame		Social Security Number
ddress	Telephone Number	Relationship
lame		Social Security Number
Address	Telephone Number	Relationship

2. Name and address of any other entity in which a person with an ownership or controlling interest in the entity also has in ownership or controlling interest.

Name of Entity	Address	Telephone Number	Name of Person with Interest
N/A			

3. Name of any person, agent, managing employee, or any other person who has ownership or controlling interest equal to five percent (5%) or greater in the entity who has been convicted of a criminal offense or assessed a civil monetary penalty related to that person's involvement in any program under Medicaid, Medicare, other federal program, or other state Medicaid program.

Name		Social Security Number
Address N/A	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation
Name		Social Security Number
Address	Telephone Number	Program Violation

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ment, between the New Mexico Human Services Department (HSD) and the applicant as provider, specifies the terms and ns for the provision of medical services to Medicaid clients. The Agreement shall be effective when completed in full with all d documentation attached and when signed by the provider and HSD, and shall remain in effect until terminated pursuant to rms set out below.

ARTICLE I – OBLIGATIONS OF THE PROVIDER

e Medicaid provider shall:

1. Abide by all federal, state, and al laws, rules, and regulations, including but not limited to, those laws, regulations, and policies applicable to provids of medical services under Title XIX Medicaid) and Title XXI (SCHIP) of the ocial Security Act and other health care ograms administered by HSD.

.2. Furnish services, bill for services, and receive payment for services nly upon approval of this Agreement y the MAD Director or his/her designee.

.3. Comply with all billing instructions, reimbursement, audit, recoupment, nd withholding provisions distributed by HSD. All rates, policies, procedures, or ules of any kind relating to billing instructions, reimbursement, audit, ecoupment, and withholding provisions furnished to providers must be specifically approved in writing by the MAD Director or his/her designee to be effective.

1.4. Maintain and keep updated program policies, instructions on billing and utilization review, and other pertinent material distributed by HSD.

1.5. Furnish and update complete information on provider address, licensing, certification, board specialities, corporate names, and parties with direct or indirect ownership or controlling interest and information on the conviction of delineated criminal or civil offenses by providers or parties with direct or indirect ownership or controlling interest at least sixty (60) days prior to the contemplated change or at least ten (10) days after the conviction. Any payment by HSD on the basis of erroneous or outdated information is the responsibility of the provider and is subject to recoupment, criminal investigative costs, and/or civil penalties;

1.6. Comply with all federal, state, and local laws and regulations regarding the provider's authority to operate a business in New Mexico including, but not limited to, licensure, registration to pay gross receipts tax, permit requirements, and employee tax filing requirements.

1.7. Assume sole responsibility for all applicable taxes, insurance, licensing, and other costs of doing business.

1.8. Verify that an individual is eligible for a specified medical program administered by HSD.

1.9. Maintain the confidentiality of client information and records in accordance with federal and state laws as required per 42 CFR § 431.305(b) and NMSA § 27-2-35 (1978).

1.10. Render covered services to eligible clients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political belief, disability, or source of payment as per 45 CFR § 80.3(a)(b); 45 CFR § 84-52.(a); and 42 § CFR 447.20.

1.11. Assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Submission of false claims or fraudulent representation may subject the provider to termination, criminal investigations and charges, and other sanctions specified in the MAD Provider Program Manual.

1.12. Retain any and all original medical or business records as are necessary to verify the treatment or care of any client for which the provider received payment from HSD to provide that benefit or service, services or goods provided to any client for which the provider received payment from HSD, amounts paid by HSD on behalf of any client, and other records required by HSD for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer. Services that have been billed to HSD which are not substantiated in the provider's record are subject to recoupment.

1.13. Upon closure of office or facility, inform HSD where records pertaining to Medicaid recipients will be located.

1.14. Furnish immediately to the Medicaid Agency, the Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested as described above and any information regarding payments claimed by the provider for furnishing services to clients. Permit the inspection of facilities used in the provision of services to clients by the U.S. Secretary of Health and Human Services, HSD, the Medicaid Fraud Control Unit, or HSD designees. Failure to comply with this provision constitutes a violation of federal and state Medicaid law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the provider shall furnish the records within five (5) working days of the receipt of the request or as provided for in the request.

1.15. Accept as payment in full the amount paid by HSD for services furnished to clients in accord with the reimbursement structure in effect for the period during which services were provided as per the HSD reimbursement policy. No exceptions to, or waiver, of standard reimbursements will be permitted without the express written consent of the MAD Director or his/her designee.

1.16. Not collect payments from the client or any financially-responsible relative or representative of that client for services furnished to the client, except as allowed and specifically delineated by HSD.

1.17. Seek payment from any other payor or insurer before seeking payment from HSD, in the event the client is covered by an insurance policy or health plan, including Medicare. Refund to HSD the lesser of the payment received from a liable third party or the amount payable under medical programs administered by HSD and not bill HSD the difference between the payment received from the third party based on a "preferred patient care agreement" or "discount" arrangement and the provider's billed charge.

1.18. Not refuse to furnish services to an eligible client because of a third party's potential liability for payment for the services, except in instances in which a client who is covered by an HMO plan is seeking services from a provider who does not participate in the HMO plan network and would not be paid for services by the HMO plan.

1.19. Inform HSD immediately when an attorney or other party requests information related to the services rendered to a client that were paid by HSD and upon receipt of any knowledge of pending or active legal proceedings involving clients.

1.20. When furnishing services to clients who sustained injury in an accident or another action that may be subject to a legal proceeding, agree to the following:

(A) Hospital providers must either file a claim with HSD within 120 days of the date of hospital discharge or impose a hospital lien on the potential recovery from the liable third party. If the hospital provider elects to impose a lien, the provider is prohibited from filing a claim with HSD for payment of any unpaid balance resulting from the third party recovery or from seeking payment from the client.

ospital providers must accept
ment made by HSD as payment
A non-hospital provider may
eek additional payment for those
ices from the client even if the
t subsequently received a monetary
rd or settlement from the liable party.

When entering into contracts the Medicaid managed care organi-ns (MCOs) contracting with HSD for provision of managed care services e Medicaid population, agree to be by the MCOs at any amount mutu-agreed between the provider or pro-r group and the MCOs, or failing that, then current and "applicable reim-sement rate" based on the provider e. The "applicable reimbursement s" is defined as the rate paid by HSD providers participating in Medicaid or ier medical programs administered by SD and excludes disproportionate share spital and medical education payments.

ARTICLE II – OBLIGATION OF THE HUMAN SERVICES DEPARTMENT

SD shall:

2.1. Distribute information neces-ary to participate in medical programs dministered by HSD, including program olicies, billing instructions, utilization re-iew instructions, and other pertinent naterials. The provider must contact HSD to request any additional program policy manuals, billing and utilization re-view instructions, and other pertinent ma-terials.

2.2. Process payments in a manner delineated by federal guidelines either internally or through a delineated fiscal agent contractor.

2.3. Reimburse providers for furnish-ing covered services or procedures to eligible clients. Reimbursement is based on the HSD fee schedule, reimbursement rate, or reimbursement methodology in place at the time services are furnished by the provider. No exception to, or waiver of, standard reimbursement will be permitted without the express written consent of the MAD Director or his/her designee.

2.4. Conduct administrative investi-gations and administrative proceedings to ensure that providers comply with the terms of this Agreement and federal and state law pertaining to the administration of the health care programs administered by HSD, including the Medicaid Provider Act.

ARTICLE III – PATIENT SELF-DETERMINATION ACT

Nursing facility, intermediate care facil-ity, hospital, home health agency, and hospice providers shall:

3.1. Furnish written information to all adult clients receiving medical care concerning their right to make decisions about medical care; accept or refuse medi-cal or surgical treatment; and formulate arrangements for a living will or durable power of attorney.

3.2. Document in the client's medi-cal record whether he/she has executed an advance directive which complies with New Mexico law on advance directives. The provision of care shall not be based on whether the client has executed an advance directive.

3.3. Inform each adult client, orally and in writing, at the time of facility ad-mission or initiation of treatment, of the client's legal rights during his/her facility stay or course of treatment

ARTICLE IV – SUBMISSION OF COST REPORTS

4.1. Providers delineated by HSD who are reimbursed on a cost basis shall furnish HSD or its designee with such financial reports, audited or certified cost statements, and other substantiating data as necessary to establish a basis for re-imbursement.

4.2. Cost statements or other data are to be furnished no later than 150 days following the closure of the provider's fiscal accounting period. Failure to com-ply with this provision will result in sus-pension of payment until the required statements and other data are provided.

ARTICLE V – STATUS OF PROVIDER

The provider, its agents, and employees are independent contractors who perform professional services for clients served through health care programs adminis-tered by HSD and are not employees of HSD. The provider shall not purport to bind HSD nor the State of New Mexico to any obligation not expressly autho-rized herein unless HSD has given the provider express written permission to do so.

ARTICLE VI – CHANGE IN OWNERSHIP

6.1. As soon as possible, but at least sixty (60) days prior to a change in own-ership or status, any provider must no-tify HSD of the proposed change in own-ership. Upon completion of the transfer of ownership, the initial provider partici-pation agreement is terminated. The new owner must complete and receive ap-proval of a new Medical Assistance Pro-vider Participation Agreement before sub-mitting any claims to HSD. Any pay-ment by HSD on the basis of erroneous information due to the lack of notice is the res nsibility of the previous provider and is ject to recou ment.

6.2. The previous owner shall be re-sponsible for any over payments and is entitled to receive pay nents from HSD up to the date of ownership transfer, unless otherwise specified in the contract for transfer of ownership.

6.3. The new owner shall furnish to HSD, upon receipt of a written request, the contract or othe applicable docu-ments specifying the terms of the change in ownership and re ponsibilities delin-eated in this Agreement.

6.4. HSD reserves the right to with-hold all pending and other claims until the right to payments and/or recoupment is determined, unless the new owner agrees in writing to be liable for any recoupment or overpayment amounts.

6.5. For providers who are reim-bursed on a cost basis and subject to cost settlements, HSD shall impose a lien and/or a penalty of up to ten percent (10%) of the purchase price against the previous owner until such time as the final cost settlement is completed and amounts owed, if applicable, are remit-ted to HSD.

ARTICLE VII – TERMINATION OF PROVIDER AGREEMENT

7.1. Provider status may be termi-nated without cause if the provider or HSD gives the other written notice of ter-mination at least sixty (60) days prior to the effective date of the termination.

7.2. HSD will terminate this Agree-ment for cause, with thirty (30) days notice, if a provider, his/her agent, a managing employee, or any person hav-ing an ownership interest equal to five percent or greater in the health care pro-vider:

(A) Misrepresents, by commission or omission, any information on the pro-vider agreement enrollment form.

(B) Has previous or current exclu-sion, suspension, termination from, or the involuntary withdrawal from participation in a health care program administered by HSD; any other state's Medicaid pro-gram, Medicare, or any other public or private health or health insurance pro-gram.

(C) Is convicted under federal or state law of a criminal offense relating to the delivery of the goods/services, or supplies, under a health care program administered by HSD, any other state's Medicaid Program, Medicare, or any other public or private health or health insur-ance program.

(D) Is convicted under federal or state law of a criminal offense relating to the neglect or abuse of a patient in con-

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with the delivery of any goods, s, or supplies.

Is convicted under federal or law of a criminal offense relating to unlawful manufacture, distribution, cription or dispensing of a controlled stance.

(F) Is convicted under federal or e law of a criminal offense relating to ud, theft, embezzlement, breach of fi- iary responsibility, or other financial conduct.

(G) Is convicted under federal or te law of a criminal offense punish- le by imprisonment of a year or more hich involved moral turpitude or acts ainst the elderly, children, or infirm.

(H) Is sanctioned pursuant to a vio- tion of federal or state laws or rules rela- ve to a health care program adminis- ered by HSD, any other state's Medic- id Program, Medicare, or any other pub- c health care or health insurance pro- ram.

(I) Is convicted under federal or tate law of a criminal offense in connec- ion with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (C) through (H) of this subsection.

(J) Violates licensing or certification conditions or professional standards re- lating to the licensure or certification of health care providers or the required qual- ity of goods, services, or supplies pro- vided.

(K) Fails to pay recovery properly assessed or pursuant to an approved re- payment schedule under a health care program administered by HSD.

7.3. Provider status may be termi- nated immediately, without notice, in in- stances in which the health and safety of clients in institutions are deemed to be in immediate jeopardy; are subject to an immediate or serious threat; or when it has been demonstrated, on the basis of reliable evidence, that a provider has committed fraud, abuse, or other illegal or sanctionable action. For purposes of this provision, institutional providers in- clude nursing facilities, intermediate care facilities for the mentally retarded, all resi- dential psychiatric treatment facilities, group homes, and other facility-based residential treatment programs.

7.4. HSD reserves the right to termi- nate this Agreement for cause as sum- marized in this Agreement and as delin- eated in Section MAD-960, SANCTIONS AND REMEDIES of the Medical Assis- tance Division Provider Policy Manual.

ARTICLE VIII – IMPOSITION OF SANCTIONS FOR FRAUD OR MISCONDUCT

8.1. If the provider obtains an excess payment or benefit willfully, by means of false statement, representation, con- cealment of any material fact, or other fraudulent scheme or devise with intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the Medicaid Fraud Act, NMSA 1978 § 30.44.1 et. seq. (Repl. Pamp. 1997) and 42 U.S.C.A § 1302,24 CFR §§ 455.12 and 455.23.

8.2. In addition to the above crimi- nal civil penalties, HSD may impose mon- etary or non-monetary sanctions, includ- ing civil monetary penalties for provider misconduct or breach of any of the terms of this Agreement.

8.3. HSD may take any or a combi- nation of the following actions against a provider for violation of the Medicaid Provider Act, NMSA 1978 § 27-11-1 et. seq. (Repl. Pamp. 1999):

(A) Imposition of an administrative penalty of not more than $5,000 for en- gaging in any practice that violates the Act; each separate occurrence of such practice constitutes a separate offense;

(B) Issue an administrative order requiring the provider to (1) cease or modify any specified conduct or practices engaged in by it or its employees, sub- contractors, or agents; (2) fulfill its con- tractual obligations in the manner speci- fied in the order; (3) provide any service that has been denied; (4) take steps to provide or arrange for any services that it has agreed or is otherwise obligated to make available; or (5) enter into and abide by the terms of binding or nonbinding arbitration proceeding, if agreed to by any opposing parties; or

(C) Suspend or revoke this Agree- ment.

8.4. HSD may elect to pursue one or a combination of all the delineated sanctions, as applicable.

ARTICLE IX - REFUSAL TO EXECUTE AN AGREEMENT

HSD will not execute an Agreement with a provider if the provider, his/her agent, managing employee, or any person hav- ing an ownership interest equal to five percent (5%) or greater in the health care provider commits or has committed any of the violations listed in Article 7.2. of this Agreement or other provisions de- lineated in Section MAD-960, REMEDIES AND SANCTIONS of the MAD Provider Policy Manual.

ARTICLE X – RECIPIENT FUND ACCOUNT

Nursing facilities, swing bed hospitals, and intermediate care facilities for the mentally retarded sh ll establish and maintain an acceptal le system of ac- counting for recipient ' personal funds, in the manner presc ibed by HSD, in those cases in which c lients entrust their personal funds to the facility.

ARTICLE XI - PI ECONDITION FOR PARTI IPATION

The provider unders tands that signing this Agreement is a p recondition for par- ticipating in health c re programs admin- istered by HSD. A p ovider understands that the provision o services, billing of services, and recei t of payments for services cannot oc ur until this Agree- ment is completed by the provider and approved for exec tion by HSD.

ARTICLE XII - NO WAIVERS

No terms or provisi ns of this Agreement shall be deemed v aived and no breach excused, unless su ch waiver or consent shall be in writing and executed by the party claiming to have waived or con- sented.

ARTICLE XIII - APPLICABLE LAW

This Agreement s all be governed by the laws of the Stat of New Mexico. All legal proceedings arising from unresolved disputes under th is Agreement are sub- ject to administra tive and judicial review as provided for i MAD-980, PROVIDER HEARING, of th MAD Provider Policy Manual.

ARTICLE X V – ASSIGNMENT

The provider sh ll not assign or transfer any obligation, luty, or other interest in this Agreement nor assign any claim for monies due un er this Agreement with- out authorizati n of HSD. Any assign- ment or transfe r which is not authorized by HSD shall b e void.

ARTICLE X – INDEMNIFICATION

The provider s all indemnify, defend, and hold harmless he State, HSD, its agents, and employee s from any and all actions, proceedings, claims, demands, costs, damages, an attorney's fees, from all liabilities or e xpenses of any kind from any sources a ccruing to or resulting from the provider o r its employees in connec- tion with the performance of this Agree- ment and fr m all claims of any person or entity that may be directly or indirectly injured or da naged by the provider or its employees in the performance of this Agreement.

ARTICLE X VI – ENTIRE AGREEMENT

This Agree ment incorporates all the agreements covenants, and understand- ings betwe n the parties hereto concern-

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bject matter contained in this ent, and all such covenants, ments, and understandings have merged into this Agreement. No r agreements, covenants, or under- ndings, either verbal or otherwise, of parties or their agents shall be valid nforceable unless contained in this eement.

This Agreement shall not be altered, changed, revised, or amended except by written instrument executed by the parties in the same manner as in this Agreement. Amendments shall contain an effective date. Any amendments to this Agreement shall not be binding upon either party until approved in writing by HSD.

ew Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and elephone number.

Contact Person: Lynn Christensen

Telephone Number: 505-476-8868

BY SIGNATURE, THE PROVIDER AGREES TO ABIDE BY AND BE HELD TO ALL FEDERAL, STATE, AND LOCAL LAWS, RULES, AND REGULATIONS, INCLUDING, BUT NOT LIMITED TO THOSE PERTAINING TO MEDICAID AND THOSE STATED HEREIN. BY SIGNATURE, THE PROVIDER SOLEMNLY SWEARS UNDER PENALTY OF PERJURY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE.

Provider Name: ~~Yes~~ CHILDREN'S MEDICAL SERVICES

Title - (If applicable): CMS PROGRAM MANAGER

Signature (Original - Blue Ink): Lynn Christensen

Date: 02/19/03

HUMAN SERVICES DEPARTMENT APPROVAL

☒ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

Dates of Agreement: From 2/21/03 To: reverification

Authorized Signature: Yolanda Cordova

Title:

Date: 3/18/03

ENTER QUANTITIES:	SNF/NF Beds	NF Beds	ICF Beds

Subject to Automatic Cancellation - Based upon revisit and correction of deficiencies

Date:

FOR HUMAN SERVICES DEPARTMENT USE ONLY

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